Management of resident at residential care facility
14HDC01571, 30 June 2017

Private hospital ~ Registered nurse ~ Healthcare assistant ~ Dementia care ~ Care planning ~ Falls ~ Documentation ~ Rights 4(1), 4(2)

While in the intensive care unit of a public hospital, a man in his fifties had a respiratory arrest and sustained a brain injury. The hospital referred the man to a needs assessment service for placement in a residential care facility. An assessment was undertaken.

It was decided to transfer the man to a residential care facility for dementia and psychogeriatric residents. The assessment was sent to the facility and, the following day, the man was admitted.

Initially, the man was reasonably settled, but his behaviour changed on the third day, in that he was less settled and began refusing some of his medications. That afternoon he became agitated and took off his glasses and squeezed them, causing a lens to fall off, which he then put into his mouth. No injuries were recorded, but his monitoring was increased.

The man fell and hit his head. A healthcare assistant who observed the fall informed the duty leader, a registered nurse, of the fall, but did not record it in the progress notes, and did not complete an incident form until the following day. The nurse did not make any record of the fall or request a referral of the man to another health professional or the hospital. In addition, the nurse did not notify the man's family of the incident, or hand over information about the fall to the night registered nurse.

The following day, another registered nurse was working the morning shift. She noticed bruising of the man's left eye, but did not record the injury or any assessments having been performed. The healthcare assistant completed an incident form that day.

At 4pm, the nurse recorded the man's fall from the previous day as a retrospective entry in the progress notes. She noted that there was grazing on the man's forehead, that he had been resistive and agitated, that observations could not be done the previous day, and that he had been placed on the list for a post-fall doctor's review.

At around 4.40pm, the man's wife visited, and was distressed to find her husband lying in bed, injured and unkempt, with the healthcare assistant sitting in the room with his feet up.

Over the next few days, the man's condition deteriorated and he became more aggressive and resistant to cares. The man was increasingly violent, and he assaulted six staff members. Assistance was requested from the DHB mental health team because staff at the facility felt that it was unsafe to look after him, and asked for him to be removed from the facility. The man was transferred to the public hospital.

Findings summary

It was found that the company that ran the facility did not provide the man with services with reasonable care and skill in that:

- The care planning was inadequate.
- The company failed to take sufficiently prompt action when the man's behaviour deteriorated.
- The management and follow-up of the man's fall, including assessment and monitoring, was poor.
- The oversight of the healthcare assistant was inadequate.
- No plan was put in place to obtain support over a long weekend following admission, if required.

Cumulatively, these failings amounted to a breach of Right 4(1).

The registered nurse's inadequate oversight of the healthcare assistant, poor response to the man's fall, and inadequate record-keeping meant that he failed to provide services to the man with reasonable care and skill and, accordingly, breached Right 4(1). The nurse failed to record the man's fall, or pass on any information about it, prior to the night staff taking over the man's care. Accordingly, the nurse failed to comply with professional standards, and also breached Right 4(2).

The healthcare assistant failed to provide services to the man with reasonable care and skill and, accordingly, breached Right 4(1).

Adverse comment was made about the facility's manager and its clinical manager.

Recommendations

A series of recommendations were made to the company that ran the facility, including to undertake an audit of the effectiveness of the changes made to its policy and procedure and report back to HDC, and to provide evidence of staff training. It was recommended that the company, the registered nurse, and the healthcare assistant each separately apologise. It was also recommended that the Nursing Council of New Zealand consider whether a competence review of the registered nurse was warranted, should he return to practise in New Zealand.